STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	RC57000060	**06/01/2018**
NAME OF PROVIDER OR SUPPLIER **SANDY PINES**	STREET ADDRESS, CITY, STATE, ZIP CODE **11301 SE TEQUESTA TERRACE** **TEQUESTA, FL 33469**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - INITIAL COMMENTS

An unannounced licensure complaint survey, CCR# 2018002308 CCR# 2018003827, CCR# 2018005285, CCR# 2018005982 and CCR# 2018007568 was commenced on and concluded on at Sandy Pines, Residential Treatment Center for Children And Adolescents facility, License Number52.
One of three allegations for CCR# 2018002308 were substantiated.
One of three allegations for CCR# 2018003827 were substantiated.
Two of four allegations for CCR# 2018005285 were substantiated.
One of three allegations for CCR# 2018005982 were substantiated.
One of three allegations for CCR# 2018007568 were substantiated.
The facility had deficiencies at the time of the investigation.

0011 - Operating - Written Procedures - 65E-9.005(2), F.A.C.

Based on interview, record review and review of the facility's Policy and Procedures, the facility failed to completely follow their Policy and Procedures for 1 of 1sampled residents requiring a treatment, as evidenced by the resident not receiving the treatment, as defined by the facility (Resident #7).

The findings included:

Review of Resident #7 Multidisciplinary Progress Note reveals evidence of documentation on that an issue requiring treatment was discovered. Review of the resident's "Medication Administration Record (MAR)," reveals there was a physician's order, on to provide treatment for 7 days with the facility's Nurse's initials and no evidence of documentation that all parts of the treatment were completed. A "Nurses Progress Note," dated documented by the facility's Unit Staff nurse reveals the resident received a treatment.
During an interview on at 12:58 PM, the Managerial Nurse stated she could not recall Resident #7's specific treatment but their normal role would be to follow up with the facility's other nurses to assure that they are following the treatment procedures and further stated that she does the "final clearance" or if needed, to continue and a "check" is done on all residents on the unit. During a further interview, with the Managerial Nurse, on at 4:30 PM, she acknowledged Resident #7 did not have any treatment.
Review of the facility's Policy and Procedures documents treatment with multiple parts and to document that all parts of the treatment are completed for 7 days.

0017 - Operating - Organization Personnel P&P - 65E-9.005(3)(h)1, F.A.C.

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Based on record review and interview, the facility failed to follow their own practices to promote the objectives of their program and ensure support of high quality of care and treatment for 4 of 9 sampled residents as evidenced by the 5-minute and 15-minute checks not completed by the staff (Resident #1, Resident #2, Resident #3 and Resident #9).

The findings included:

Record review reveals Resident #1, Resident #2 and Resident #9 are on 15-minute "checks." A review of the cameras with the facility's Risk Manager, on at 10:55 AM, reveals that on , Staff "A" did a resident "check" at 7:59 PM with Resident #1, Resident #2 and Resident #9. Further review reveals the next resident "check" was not completed until at 8:22 PM, 23 minutes after the first "check" was completed. Continued review reveals the next "check" was not completed until at 8:45 PM, 25 minutes since the last "check" was completed. Further review reveals the next "check" was completed on at 9:01 PM, 16 minutes after the last "check."
Continued review reveals that on , Resident #1 is on 5-minute supervision "checks" around the clock and Resident #3 is on 15-minute supervision "checks." On , at 3:09 PM, , until 3:34 PM, review reveals a total of 5 "five-minute checks" were not completed for Resident #1 and 2 "fifteen-minute checks" were not completed for Resident #3. During interview on at 1:10 PM, the Director of Residential Services stated that all staff received the mandatory "Back to Basic" training held between - . During an interview on at 3:40 PM, Staff "A" states, "If I am late on "checks," I still put my initials in the box but I don't change times."